

**STUDENT CONSENT FOR ACCESS TO EDUCATION RECORDS**  
 THE UNIVERSITY OF NORTH CAROLINA AT CHARLOTTE  
 OFFICE OF THREAT ASSESSMENT AND MANAGEMENT

|   |                      |                |
|---|----------------------|----------------|
| Name of Student (Last, First, Middle Initial):<br>_____ | Student ID:<br>_____ | Date:<br>_____ |
|---|----------------------|----------------|

The Family Educational Rights and Privacy Act (FERPA) affords certain rights to students concerning the privacy of, and access to, their education records. Students may choose to complete and submit this form allowing the release of their education records to specified third parties. Please note that while this form *authorizes* UNC Charlotte to release education records to third parties, it does not *obligate* UNC Charlotte to do so. UNC Charlotte reserves the right to review and respond to requests for release of education records on a case-by-case basis. For additional information, visit UNC Charlotte’s FERPA Information page at <http://legal.charlotte.edu/legal-topics/ferpa> or the U.S. Dept. of Education’s website at [www.ed.gov/policy/gen/guid/fpco/ferpa/index.html](http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html).

**SECTION A. Education records to be released (check all that apply):**

**Education Records or Information** (please specify):  
 \_\_\_\_\_  
 Office of Threat Assessment and Management  
 \_\_\_\_\_

**SECTION B. Person(s) to whom access to education records may be provided:**

\_\_\_\_\_  
 Name(s) of person(s) to whom access to records may be provided (use additional pages if necessary)

\_\_\_\_\_  
 Address(es) of person(s) to whom access to records may be provided

\_\_\_\_\_  
 Relationship to Student

**SECTION C. Duration of release (check one):**

**One-Time Use:** This authorization can be used only once.

**Limited Use:** This authorization expires on: \_\_\_\_\_

**SECTION D. Purpose of release (check one):**

**Family Communications**

**Communications with counselor, psychologist, or other medical/treatment provider**

**Discussion/meeting with University personnel that includes third parties (parents, friends, others)**

**Other** (please specify): \_\_\_\_\_

I understand that (1) I have the right not to consent to the release of my education records, (2) I have the right to inspect any written records released pursuant to this consent, and (3) I have the right to revoke this consent at any time by delivering a written revocation to the Threat Assessment Coordinator or University Registrar.

\_\_\_\_\_  
 Student's Signature

\_\_\_\_\_  
 (Date)

Instructions for completing this form:

1. The form must be fully completed and signed by the student. Records cannot be released if any section of this form is not filled out entirely.
2. If the records covered by this release are housed within only one office, the completed form should be maintained with the student’s file in that office. If the records covered by this release are housed in multiple offices, then completed forms should be submitted to the Office of the Registrar in Room 141 of the King Building, or mailed to Office of the Registrar, UNC Charlotte, King 141, 9201 University City Boulevard, Charlotte, NC, 28223; or faxed to the Office of the Registrar at (704) 687-6121. Questions about this form may be directed to the Office of the Registrar at (704) 687-5505.

*This information is released subject to the confidentiality provisions of appropriate state and federal laws and regulations which prohibit any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.*